Child's Name:_____ **Date of Birth:**_____

Diagnosis:_____

Allergies:_____

Medications:_____

Today's Date:_____ **Form Completed By:**_____

Please answer the following questions about your child's health and development so we can help with your needs.

Staff Only *F/U*	**Staying Healthy** **Medical Home:**_____	**YES**	**SOME-TIMES**	**NO**
	1. Do you have a medical home (family doctor or clinic) that you go to when your baby is sick or needs a check-up?			
	2. Does your baby have regular check-ups with the medical home provider? (2,4,6,9, &12 months)			
	3. Are your baby's immunizations up-to-date?			
	4. Are you happy with your baby's weight?			
	5. Do you clean your baby's mouth at least daily?			
	6. Has your baby started eating baby food (4-9 months) and/or table food (9-12 months)?			
	7. Does your baby sleep well?			
	8. Does your baby have at least one dirty diaper a day?			
	9. Do you regularly fasten your baby into a car seat?			
	10. Do you understand the dangers of second-hand smoke on babies?			

Name:_____ ID #:_____

Staff Only *F/U*	**Managing Your Infant's Healthcare** **Drugstore:**_____	**YES**	**SOME-TIMES**	**NO**
	11. Do you understand your baby's health problems?			
	12. Do you participate in your baby's treatment? (medications, exercises, therapy)			
	13. Are you being taught how to do your baby's treatments?			
	14. Are you continuing your baby's treatments at home when the healthcare providers aren't present?			
	15. Do you feel that your baby's identified needs are being met?			
	16. Do you know when, how much, and why your baby gets medications? (prescription and over-the-counter, like Tylenol)			
	17. Do you know the side effects of your baby's medications?			
	18. Are you able to get the medications, supplies, and/or equipment your baby needs?			
	19. Do you know how to use your baby's insurance and/or Medical Card?			

Name:_____ ID #:_____

Staff Only *F/U*	**Interacting with Others**	**YES**	**SOME-TIMES**	**NO**
	20. Has your baby started making noises?			
	21. Does your baby react to things around him/her?			
	22. Do you and your baby get to have some fun together every day? (playing games, reading, singing)			
	23. Do you have time to take care of some of your own needs?			
Staff Only *F/U*	**Commission Satisfaction**	**YES**	**SOME-TIMES**	**NO**
	24. Are you pleased with the care you receive at the Commission?			

What would you like to see done differently:

Information You Would Like to Have:

- ❍ Growth & Development
- ❍ Early Intervention
- ❍ Health Information
- ❍ Counseling
- ❍ Assistance Programs
- ❍ Medicaid
- ❍ Social Security
- ❍ Transportation
- ❍ Other:_____

Your Comments:

Name:_____ ID #:_____

STAFF USE ONLY:

Reviewed By:

Initials	Signature	Date